

Safety Leadership and HOF: Where do we go from here?

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Background

- Offshore oil and gas industry
- Conventional power generation
- Air Traffic Control
- Maritime Industry
- Healthcare sector
- Nuclear Industry

- Researcher, Regulator, Practitioner

Areas of research

- Risk Perception
 - Safety culture/safety climate
 - Health climate
 - HOF in Incident investigation
 - Safety leadership
 - Safety intelligence
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- Main interest has been the organisational factors that influence human performance

Findings

- Different industries, same issues:
 - Perceived lack of management commitment to safety;
 - Inadequate communication;
 - Inadequate procedures;
 - Inability to ‘speak up’ about safety;
 - Inability to implement lessons learned.

Analysis of Major Accidents

- Decision-making (safety not a priority)
 - Challenger; Ladbroke Grove;
- Focus on the wrong type of indicators
 - Texas City; Deepwater Horizon;
- Inadequate regulation
 - Deepwater Horizon; Fukushima Daiichi;
- Lack of Leadership for Safety
 - Probably all of them!

Incident Investigation

- Incidents usually arise from the actions of front-line staff (errors/non-compliances);
- Proper root cause analysis usually identifies ‘latent conditions’ that have been residing within the organisation;
- ‘Setting up’ front-line staff to fail;
- Lack of management commitment to safety through decision-making processes, resource allocation, inconsistent messages and actions.

We know what the problems are

- Large body of research corroborates what we know about organisational issues and safety;
- Regulators and industry bodies publish plenty of guidance to support industry;
 - UK Health and Safety Executive; International Atomic Energy Agency; EUROCONTROL; Energy Institute; Oil and Gas Producers; OECD;
- What are the barriers to implementing our research knowledge and guidance?
 - What are the barriers to ‘learning lessons’ in the widest sense?

How can the Regulator contribute to safety?

- Do we need more scrutiny and more powers to enforce rather than just looking at 'expectations'?
- Office for Nuclear Regulation (ONR) Safety Assessment Principles:
- MS1 to MS4;
 - Leadership
 - Capable Organisation
 - Decision Making
 - Learning

Mindful leadership

- Same as Safety Culture Assessments?
 - Seeking the views of frontline staff to gain a more realistic picture of operations;
 - Encouraging ‘bottom-up’ communications;
 - Providing the necessary resources for safety;
 - Using accidents that occur in other organisations and industries as opportunities to learn;
 - Proactively commissioning audits to diagnose weaknesses in the organisation’s defences and be willing to **accept and act** on ‘bad news’.

Discussion

- What is the correct mix between guidance and enforcement?
- What level of detail does the regulator set for 'Organisational' requirements?
- What does the regulator regulate – the process or the outcome?
- What other ways are there to make progress?
 - Benchmarking within and between sectors?